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Quick Look:

This document includes: Background Information, Quick Facts, Frequently Asked Questions and Additional Resources about House Bills 7107 and 7109 sponsored by the House Health & Human Services Committee chaired by Representative Schenck**.**

Quick Facts:

1970: The year Florida first implemented the Medicaid Program

307,687: Total number of Medicaid patients statewide in 1970

$43 million: Total cost of Medicaid to the state in 1970

2.97 million: Total number of Medicaid patients statewide in 2010-11

$20.2 billion: Estimated expenditures for Fiscal Year 2010-11

OPI Pulse: Medicaid Reform

Background

Medicaid is a government program created to pay for health care services for low-income individuals and provide long-term care for aged individuals and individuals with developmental disabilities. The program is a state and federal partnership with each partner contributing a share of the funding—in Florida, the federal government pays about 56 cents of every dollar spent. Each state Medicaid program is unique, but all states must comply with certain federal standards for eligibility, service coverage and payment policies. Over the years, the Florida Legislature has authorized numerous special initiatives, changes in services, and various payment arrangements for Florida's Medicaid program. Today, Florida Medicaid is a complex system serving different groups of people using different service delivery methods. Currently, Medicaid serves about 2.97 million people in Florida.

State Administration

In Florida, the Agency for Health Care Administration (AHCA) is responsible for administering the Medicaid program. The agency contracts with other state agencies and private organizations to provide a broad range of program services. Medicaid covers a wide range of benefits, including physician and hospital services, prescriptions drugs, therapies, and laboratory tests. Individuals receiving long-term care services enroll to obtain services such as medication assistance, in-home medical care or placement in a nursing home. Elder long-term care services are administered in partnership with the Department of Elder Affairs. Medicaid also covers home and community-based services for individuals with developmental disabilities, which are administered by the Agency for Persons with Disabilities. These specialized services include in-home support, supportive employment and personal care assistance. In order to be eligible to receive Medicaid services, certain income limits apply. Some services are also subject to clinical eligibility criteria.

Payment for Services

Medicaid services in Florida are financed through both fee-for-service processes and pre-paid managed care systems. In the fee-for-service system, the program sets payment rates for each service or procedure, and reimburses providers after services are delivered to the patients. Florida Medicaid contracts with nearly 100,000 individual providers.

In the managed care system, care is organized by health maintenance organizations or provider service networks. A Medicaid recipient may choose from different providers in the network in order to receive services. The state pays the health plans a per-member, per-month payment to cover all medical needs of the Medicaid patients enrolled in

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Terms to Understand:

Provider Service Network (PSN) – A managed care network established and operated by a health care provider or group of affiliated health care providers.

Health Maintenance Organization (HMO) – A type of health care coverage relying on a specific network of providers to deliver health services that are paid for on a per-member, per-month basis.

Managed Medical Assistance – would provide coverage for routine health care needs such as doctors visits, pregnancy care, prescription drugs, hospitalization, etc., in a managed care system.

Managed Long-Term Care – would provide individuals who are aged and/or disabled a variety of support services such as medication assistance, adult day care, in-home services, assisted living and nursing facility services, transportation, etc., in a managed care system.

the plan. Approximately 1.9 million of Florida's 2.9 million Medicaid recipients are enrolled in some type of managed care.

Not all healthcare providers accept Medicaid patients, and access to services varies greatly by geographic region. Availability of managed care also varies by region, and managed care plans are more likely to be present in more populated areas. In some areas, fee-for-service care is the only option.

Medicaid Costs

In 1970, when Florida's Medicaid program was first implemented, the state spent $43 million to cover the cost of 307,687 recipients, for an average of $140 per recipient. By the year 2000, Medicaid was serving 1.6 million recipients at a cost of $7.8 billion annually. Medicaid spending in Florida has doubled since 2002. In 2009-10, Florida spent $18.8 billion or approximately 28 percent of the total state budget on the Medicaid program. Current estimates indicate Florida will spend $6,733 per Medicaid recipient in 2010-11. Over half of Florida's Medicaid recipients are children and adolescents 20 years of age or younger. The aged and individuals with developmental disabilities make up less than 30 percent of Florida's Medicaid recipients but they account for approximately 60 percent of all Medicaid spending.

Pilot Project

In 2005, the Florida Legislature created a Medicaid pilot project which was implemented in 2006. The program expanded managed care in specific counties around the state including Broward and Duval counties. In participating counties, nearly all Medicaid recipients were required to choose and enroll in a managed care plan. AHCA contracted with willing, qualified managed care plans to provide services in the area, and the plans then competed for recipients.

Issue at a Glance

During the 2011 Legislative Session, the Florida House of Representatives Health & Human Services Committee filed two bills, House Bill 7107 and House Bill 7109, aimed at reforming the state's Medicaid program. Proponents of the bills assert reform is necessary because Florida Medicaid in its current form is unsustainable and is not delivering value for either consumers or taxpayers. Proponents of the bill have raised the following concerns with the current system:

- The costs to administer Florida's Medicaid program are rising, but this growth in expense is not resulting in any improvement in the quality of services to recipients.
- Access to care is uncertain; proponents assert patients have trouble finding physicians and other providers who will accept Medicaid payment.

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Medicaid Basics

- Not all health care providers accept Medicaid.
- Some limitations apply to covered services.
- Medicaid sets a fee for each individual type of service and procedure.
- Medicaid payments are made directly to the health care provider, not the recipient of health care.
- Florida's Medicaid Program contracts with 25 care organizations, including 19 HMOs and 6 PSNs.
- Medicaid spending has doubled since 2002.
- The Florida House of Representatives proposed and passed similar reforms during the 2010 Legislative Session. The Senate did not take up this Legislation in the 2010 Session and therefore, the proposed reforms did not take effect.
- In November 2010, the Legislature passed a joint Medicaid Memorial defining the issues surrounding the program's current structure and declaring the guiding principles of proposed reforms.
- With access and quality uncertain while costs continue to grow, proponents believe the value and stability of Medicaid is eroding for both patients and taxpayers.
- Efforts to measure and improve the quality of care of the Medicaid program have been limited and unevenly applied.
- The system's current structure has been ineffective in protecting against fraud resulting in the loss of critical resources.
- The complexity of the current program, with various "pilot" programs, exceptions and geographic variations makes it difficult to administer.

What the Bills Do

House Bill 7107 re-creates the Florida Medicaid Program as a statewide, integrated managed care program consisting of two elements: Managed Medical Assistance for current recipients of general Medicaid services and Managed Long-Term Care for current recipients of long-term care Medicaid services. House Bill 7109 makes date-specific, conforming changes which align existing law to the changes in House Bill 7107. House Bill 7101 passed the House with a vote of 79-39 and the Senate with a vote of 28-11. House Bill 7109 passed the House with a vote of 80-39 and the Senate with a vote of 26-12. Both bills were passed on the final day of the 2011 Legislative Session. The language proposes to:

- Eliminate the existing fee-for-service structure providing all Medicaid recipients with a choice of managed care plans including traditional Health Management Organizations (HMOs), Provider Service Networks (PSNs), and specialty plans with expertise in specific medical conditions.
- Establish eleven state regions within which plans will compete for state Medicaid contracts based on value.
- Limit the number of plans allowable in each of the eleven regions in order to promote plan stability, while also providing choices to recipients.
- Improve managed care accountability with provider network standards, auditing, accreditation requirements, continuous improvement requirements, performance monitoring, penalties for early withdrawal, and prompt payment and fraud and abuse requirements.
- Pay plans risk-adjusted rates, based on patient encounter data. Risk-adjusted rates will ensure plans are paid more for sicker patients in order to allocate resources appropriately and discourage plans from trying to enroll only healthy patients.
- Require achieved savings rebates to incentivize plans to improve patient outcomes and cost-effective health services.

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Additional Resources:

Agency for Health Care Administration-Medicaid

Florida Medicaid Summary of Services

U.S. Centers for Medicare and Medicaid Services

Department of Children and Families

Agency for Persons with Disabilities

Frequently Asked Questions: Medicaid Reform

Who is responsible for determining Medicaid Eligibility?
The Social Security Administration determines eligibility for Supplemental Security Income (SSI). Recipients of SSI are automatically eligible for Medicaid.

The Florida Department of Children and Families (DCF) determines eligibility for low-income children and families, aged persons, persons with disabilities, and persons seeking institutional care.

Once eligible, who is responsible for enrolling eligible persons in the Medicaid program?
The Department of Children and Families is responsible for enrolling Floridians in Medicaid.

What is an HMO (Health Maintenance Organization)?
HMOs are health plans that rely on a specific network of physicians and other providers to deliver health services to the plan enrollees. HMOs are prepaid – receiving a fixed amount per member per month – and must bear the risk of covering medically necessary care with that fixed amount.

What is the difference between Medicaid and Medicare?
Medicaid is the state and federal partnership that provides health coverage for certain people with low incomes who are eligible because of their age, financial situation, and medical condition.

Medicare is a federal health insurance program for people who are age 65 or older or disabled. It is administered by the federal Department of Health and Human Services and Centers for Medicare and Medicaid Services (CMS). Eligibility for Medicare is not based on the person's income or assets.

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